	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209			LDING	ONSTRUCTION  00	(X3) DATE SU COMPLET 10/05/2	ΓED
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323				
	ARC OF NORTHWEST INDIANA INC, THE				JND, IN <del>1</del> 0020		(37.5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	3	(X5) COMPLETION
TAG	· ·	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RIATE	DATE
W0000							
	This visit was for complaint #IN0	or the investigation of 0117084.	Wo	000			
	COMPLAINT	#IN00117084:					
	deficiencies rela	TED, Federal and state ated to the allegations are W148, W149, W153,					
	Dates of Survey 5, 2012	y: October 1, 2, 3, 4 and					
	Facility number Provider number AIM number: 1	er: 15G209					
	Surveyor: Chris Surveyor III/QN	stine Colon, Medical MRP					
	1	ederal deficiencies also lings in accordance with					
		was completed on n Shebel, Medical					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000736

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLE			ETED	
		15G209	B. WING 10/05/2012			2012	
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				EBRASKA		
ABC OF	NODTHWEST INDI	ANA INC. THE			OND, IN 46323		
ARC OF NORTHWEST INDIANA INC, THE			I IAIVIIVIC	JND, IN 40323			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W0111	483.410(c)(1) CLIENT RECORD The facility must or recordkeeping syclient's health car information, and prights.  Based on observer record review for (client A), the fact pertinent information client's health was chart/records.  Findings include  An evening obsetthe group home of P.M. until 6:30 F. group home, client to be dark black corner to the outon Direct Support P. indicated client A for about a week  A review of the for about a week.  A review of the for about a week.	develop and maintain a stem that documents the re, active treatment, social protection of the client's ation, interview and r 1 of 2 sampled clients cility failed to ensure all ation in regard to the as part of the client's revation was conducted at the result on 10/1/12 from 5:30 P.M Upon entering the ent A's eye was observed and blue from the inner recorner of his left eye. Professional (DSP) #1 A's eye has been like that	W0	111	A procedure is in place but wa not followed in this instance. T Community Services Nurse wi be trained on the procedure to document injury and assessments. (10/29/12) To ensure future compliance to Community Services Nurse wi document all treatments and assessments of any reported injury in the client medical cha	s he II	10/29/2012
	-	eview of the facility's					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 2 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED		
		15G209	B. WING		10/05/2012
			STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	ę.	6511 N	EBRASKA	
	NORTHWEST IND	IANA INC, THE	HAMMOND, IN 46323		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	BEFELENCT	DATE
		/24/12: "[Client A] stated			
		d Safety Tech, that over			
		nis family (sic) house, he			
	_	an unnamed male, who			
		ce. [Client A] did not			
	report incident to	o staff over the weekend.			
	Stated he (client A) forgot."				
	A review of clie	nt A's record was			
	conducted at the facility's administrative				
	office on 10/2/12 at 3:30 P.M A review				
	of client A's record failed to indicate				
		ents to address client A's			
	_				
	_	ndicate the client was sent			
		or an assessment of his			
	1	last entry in client A's			
		/19/12 in regard to an			
	unrelated audiog	gram follow-up.			
	An interview wi	th Licensed Practical			
	Nurse #1 (LPN)	was conducted on			
	10/3/12 at 2:49 I	P.M When asked if she			
	assessed client A	A's injury of unknown			
		stated "I am not the nurse			
	1	group home, but I did go			
		nt A] on Wednesday,			
	_	f his eyes looked red and			
		eye, but like he had			
	· /	LPN indicated she did not			
		jury in client A's record.			
	The LPN further				
		should be documented in			
	clients records.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 3 of 42

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G209		A. BUILDING B. WING  A. BUILDING B. WING  A. BUILDING B. WING  A. BUILDING B. WING  B. WING  A. BUILDING B. WING  B. WING  COMPLETED 10/05/2012			IPLETED		
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323				
	NORTHWEST IND SUMMARY S (EACH DEFICIEN		STREET A	EBRASKA	ECTION OULD BE	(X5) COMPLETION DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 4 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G209		(X2) MU A. BUIL B. WINC	DING	onstruction 00	(X3) DATE : COMPL 10/05/	ETED	
	PROVIDER OR SUPPLIER			6511 NE	ADDRESS, CITY, STATE, ZIP CODE EBRASKA DND, IN 46323		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	j	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG W0148	483.420(c)(6) COMMUNICATION PARENTS & The facility must in parents or guardial incidents, or charmincluding, but not accident, death, a absence.  Based on record 1 of 1 investigation involving 1 of 2. A), the facility farential involving 1 of 2. A), the facility farential involving 1 of 2. The facility of unknown original involving 1 of 2. A review of the facility of unknown original includes the conducted at the office on 10/2/12/12/12/12/12/12/12/12/12/12/12/12/1	on WITH CLIENTS, notify promptly the client's an of any significant ages in the client's condition limited to, serious illness, abuse, or unauthorized  review and interview for on records reviewed, sampled clients (client ailed to immediately advocate/health care mily member of an injury in.	W01		A procedure for contacting far and/or guardians is in place. However the Service Coordinates was unable to reach the family this time. The Behavioral Heat Director will review the procedure with the Service Coordinator for proper reporting procedure. (10/29/12) To ensure future compliance the Service Coordinator will promptly notificate parents or guardian/advocate any significant incident or changes in the client's conditional including but not limited to ser illness, accident, death, abuse unauthorized absence. W148-A procedure for contact family and/or guardians is in place. However the Service	mily ator y at lth dure for of on rious e, or	10/29/2012
	Services (BDDS the following income Incident dated 9/ to the Health and the weekend at had a fight with a him in his face.	opmental Disabilities ) report which indicated eident:  24/12: "[Client A] stated I Safety Tech, that over his family (sic) house, he an unnamed male who hit [Client A] did not report over the weekend. Stated			Coordinator was unable to reathe family at this time. The Behavioral Health Director will review the procedure with the Service Coordinator for proper reporting procedure. (10/29/12) To ensure future compliance to Service Coordinator will promotify parents or guardian/advocate of any significant incident or changes the client's condition including not limited to serious illness,	r 2) the ptly	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 5 of 42

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	A. BUILDING COMPLETED		
		15G209	B. WIN			10/05/2012
e o o o					ADDRESS, CITY, STATE, ZIP CODE	ı
NAME OF I	PROVIDER OR SUPPLIE	£R		6511 N	EBRASKA	
ARC OF	NORTHWEST IN	DIANA INC, THE		HAMMO	OND, IN 46323	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG		DATE
	he (client A) forgot."				accident, death, abuse, or unauthorized absence. Servic	<u> </u>
					Coordinator will document	
		of the BDDS report dated			attempts and contacts made in	n
		ed: "Indicate which of the			case note form.	
		cies and individuals have				
	been informed:	Legal Guardian? N/A."				
	Δn interview w	rith the investigator was				
		e facility's administrative				
		-				
	office on 10/4/12 at 11:00 A.M The					
	investigator indicated advocates/health					
	1 *	tives/family members				
		ied immediately when an				
		involving a client. When				
	asked if client	A's advocate/health care				
	representative/f	family member was				
	immediately no	tified, the investigator				
	indicated he did	d not notify client A's				
	advocate/health	care representative/family				
	member of the	injury. No further				
	documentation	was available for review				
	to indicate clier	nt A's advocate/health care				
	representative/f	family member had been				
	informed of the	-				
	An interview w	rith the day program Health				
	and Safety Tech	h (HST) was conducted on				
	_	P.M The HST indicated				
	she was the per	son who documented				
		y. The HST indicated she				
	1 .	ury immediately to her				
	1 -	e HST further indicated				
	she did not con					
	auvocate/neattr	a care representative/family				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 6 of 42

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G209	A. BUILDING	00	COMPLETED 10/05/2012
		100200	B. WING	ADDRESS CITY STATE 7ID CODE	10/00/2012
NAME OF P	PROVIDER OR SUPPLIER	R		ADDRESS, CITY, STATE, ZIP CODE EBRASKA	
	NORTHWEST IND		HAMMO	OND, IN 46323	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
1710		e them aware of his injury.	ING	·	DATE
	0.2.2(a)				
	9-3-2(a)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet Page 7 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A PUBLIC DING (COMPLETED)			
111,512,111	or condition,	15G209	A. BUILDING B. WING		10/05/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R		EBRASKA	
ARC OF	NORTHWEST IND	IANA INC, THE	HAMM	OND, IN 46323	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
W0149	483.420(d)(1)	R LSC IDENTIFYING INFORMATION)	TAG	BLITCLENCTY	DATE
VV0149	STAFF TREATM The facility must written policies a	IENT OF CLIENTS develop and implement nd procedures that prohibit eglect or abuse of the client.	W0149	Service Coordinator will review	M 10/27/2012
	Based on observer interview, for 1 of an injury of use involving 1 of 2 A), the facility rows "Policy for Hand and Abuse."  Findings included An evening obset the group home P.M. until 6:30 group home, [cl. have dark black his inner to oute A] was asked whe stated "A big eye." When ask the person hit his An interview with Professional #1 the group home DSP #1 stated "[client A] got the	vation, record review and of 1 investigation records inknown origin reviewed sampled clients (client neglected to implement its dling Cases of Neglect	W0149	Service Coordinator will review reporting requirements of abus neglect and exploitation of clie with the DSPs and document review. Staff will monitor client all times for safety. (10/27/12) To ensure future compliance, Area Manager, Service Coordinator and/or Community Services Nurse will monitor all incident reports regarding abuneglect, or exploitation as soo as they are submitted. An investigation will be conducted immediately if determined necessary for all injuries of unknown origin and/or reports abuse, neglect, or exploitation	se, ents this ts at an y se, n

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 8 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTI	PLE CO	NSTRUCTION 00	(X3) DATE S COMPLI	
ANDILAN	OF CORRECTION	15G209	A. BUILDIN	G		10/05/2	
			B. WING ST	REET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			EBRASKA		
ARC OF	NORTHWEST INC	DIANA INC, THE	H	AMMC	DND, IN 46323		
(X4) ID		STATEMENT OF DEFICIENCIES	II		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	<b>\</b>		I	PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)			
		they said it's from him					
	rubbing his eyes	•					
	allergies."						
		facility's Bureau of					
	Developmental	Disabilities Services					
	` ' *	was conducted at the					
	1	strative office on 10/2/12					
	at 1:55 P.M Review of the facility's						
	BDDS reports in	ndicated:					
	Incident dated 9/24/12: "[Client A] stated						
		d Safety Tech, that over					
		his family (sic) house, he					
		an unnamed male, who					
	_	ce. [Client A] did not					
		o staff over the weekend.					
	Stated he (client	t A) forgot."					
	A raviany of inv	estigation record #18085					
		was conducted on 10/2/12					
		eview of the record					
	indicated the fol						
		<u>U</u>					
	"Facts not suppo	orting this allegation:					
	Client keeps cha	anging his story, now says					
		edAt one point client					
	,	ght at family home but					
	1	to family home the					
	_	stionClient has seasonal					
		story of rubbing eyes and					
		eye' to appearNurse					
	-	nd did not see anything she					
	would consider	a black eye from being					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet Page 9 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G209	B. WIN			10/05/2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					EBRASKA	
ARC OF	NORTHWEST IND	IANA INC, THE		HAMMO	OND, IN 46323	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		e nursing evaluation and				
		metimes fictious) stories				
	1 -	s that the client was not				
	hit and caused th	•				
	inadvertently hir	nself."				
	IID / 0/06/10	M I				
		Phone Interview: [Group				
	_	[Group home staff #3]				
	1	Monday morning asked				
	[client A] about it was told it happened at					
	home, asked [client A] he said he went					
		end [Group home staff				
	_	nust have happened				
		me staff #3] says he				
		e log but did not do an				
	_	[Group home staff #3]				
	was on duty Mo	nday morning."				
	UD / 0/22/12 I					
		Phone Interview: [Group				
	_	[Group home staff #4]				
		ed Saturday and Sunday at				
		Home. She worked an				
		00 P.M. shift. She stated				
		y conflict with the other				
	_	nt A]. They did go to the				
	0 1 1	ut he did not go home				
		he did the previous				
		did not notice anything				
	wrong with his e	eye during her shift."				
		Main Center: [Service				
	_	At approximately 10				
		I received a call from				
	[Day program H	ealth Safety Tech name]				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet Page 10 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G209			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/05/2012
	PROVIDER OR SUPPLIED		STREET 6511 N	ADDRESS, CITY, STATE, ZIP CODE EBRASKA OND, IN 46323	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	center with a blastaff that he was he was outside a him in the eye. when I went to to [client A], he that the picnic in the guy punched hir stated he hit the knew the guy annice.' I asked if person and he in he's like me. He questions on 9/2 the second person has a history of seasonal allergies BSP (Behavior Stargeted behavior "Date 9/26/12" Director]: [Servinformed me that eye and that she it. He said that Grounds talking bathroom and the When asked who A] stated he hit Coordinator #1] [client A] indicat white guy that h	t [client A] came into the ck eye. [Client A] told at his family's house and a big white man hit Through further questions he group home to talk to en told me that he was at bathroom and the white in in the eye. He also guy back. I asked if he d he said 'No but he was the guy was a family terrupted and said 'No et talks like me.' Later 5 did not determine who en was. [Client A] also seizures and severe es. [Client A] also has a Support Plan) with a er of false reporting."  Main: [Behavioral Health ice Coordinator #1] t [client A] had a black had talked to him about he was at the Fair to a male client in the at that client hit him. It has a he did about it [client him back. [Service is conversation with ted that this was a big is ewas having a she while in the bathroom.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 11 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G209			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  10/05/2012
	PROVIDER OR SUPPLIEI		6511 N	ADDRESS, CITY, STATE, ZIP CODE EBRASKA OND, IN 46323	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	a list of other resthat could have him and were lother pictures to find this altercate. Assurance Directly while [Service Coording on the Estroice Coording a meeting."  "Date 9/26/12  "I): The morning [Health and Safermenthat [client And Safermenth the went home. Picnic on Satured Tech #1] called to find out if he Coordinator #1] Tech #1] that he picnic. [Health out an Incident/BDDS (report)."  "Date 9/26/12 Tech #1]: Upon was met by [client has been been by [client has been been been been been been been bee	nator #1] and I developed sidential male consumers had a conversation with oking to have him look at gure out which client he ion with. [Quality etor #1] came to my office Coordinator #1] and I were list. I forwarded the list to nator #1] and then went to [Day Program Supervisoring of September 24, 2012, ety Tech #1] reported to [A], got into a fight when I stated that he was at the lay, so [Health and Safety [Service Coordinator #1] was there and [Service told [Health and Safety ewent home after the and Safety Tech#1] filled [Accident report and did a [Accident report and did a [Accident report and did a [Accident stated to me had a fight. (sic) I asked (e), he said a boy hit him fight. I asked where and know (sic). I asked do ing about the boy, was he			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 12 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE :	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G209	B. WIN	G		10/05/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
400.05	NODEL BAJECT IND	IANA INO TUE			EBRASKA		
ARC OF	NORTHWEST INDI	ANA INC, THE		HAMMC	OND, IN 46323		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)		TAG	BEI ICIENCI)		DATE
	,	no. I told him to have a					
	seat. I went and informed [Day Program						
	Supervisor #1], that [client A] was in my office, he stated he had been in a fight. I						
		<del>-</del>					
	-	a black mark underneath					
		redness and scratches on					
	_	his eye socket. She stated					
		happen here. I told her I					
		ntact [Service Coordinator					
	#1], to see if she knew and had the staff						
	made an incident report and a BDDS						
		[Service Coordinator					
		d her of [client A]'s					
		ted she had not been					
		her I would be doing an					
	_	nd [client A] stated he					
		en incident happen (sic).					
	•	estioning, she informed					
	_	.] went home after the					
		on him which home, the					
		is family home. [Client					
	_	the difference. I asked					
		home his group home					
		onsumers or his family					
		and brothers. He stated					
	1	I called [Service					
	_ =	and informed her that					
		was his family home.					
		nake sure when I make					
	_	ort and the BDDS (report)					
	_	at that the altercation did					
		e group home, but at the					
	<u>-</u>	nformed [Day Program					
	Supervisor #1] o	f my conversation with					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet Page 13 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G209	B. WING		10/05/2012
NAME OF I	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE	
ARC OF	NORTHWEST IND	NANA INC. THE		NEBRASKA IOND, IN 46323	
	•			T +0323	(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	``	ULATORY OR LSC IDENTIFYING INFORMATION)		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	[Service Coord	inator #1], and I would be			
		and incident report. Upon			
	_	ning, he informed me it			
	^	e. When he said home I			
	informed [Day	Program Supervisor #1]			
		ient A] was at picnic,			
		rvice Coordinator #1]			
	asked me to ask	[client A] which home,			
		t to his family house after			
	the picnic."				
	"Date 9/26/12:	West Center[Client A]:			
	Open ended que	estionsDo you live in			
	Nebraska Group	p Home?'Yes.'Did you			
	do anything this	s last weekendNo			
	answerDid yo	ou go to the			
	picnic?'Yes.'	Did you have fun?'Yes,			
	I rode the swing	g.'What happened to your			
	eye?'Woke up	and it was like			
		hit you?'No.'Are the			
	group home sta				
	T	you like the group home			
		Are the center staff mean			
		So you just woke up and			
	your eye was li	ke that?'Yes.'			
	An intomicor	ith Licensed Practical			
	` '	) was conducted on P.M When asked if she			
		A's injury of unknown			
	3 3 7	stated "I am not the nurse			
	_	group home, but I did go			
	-	ent A] on Wednesday,			
	9/26/12. Both o	of his eyes looked red and			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet Page 14 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTI	PLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	00	COMPL	ETED
		15G209	B. WING			10/05/	2012
NAME OF I	PROVIDER OR SUPPLIE	D	ST	REET A	ADDRESS, CITY, STATE, ZIP CODE		
			6	511 NE	EBRASKA		
ARC OF	NORTHWEST IND	DIANA INC, THE	H	AMMC	OND, IN 46323		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	II	)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	COMPLETION
TAG	<b>†</b>	R LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
		eye, but like he had					
	allergies."						
	A review of the	facility's "Policy for					
		of Neglect and Abuse"					
	_	was conducted at the					
		istrative office on 10/3/12					
	1	eview of the facility's					
		l: "In order to protect the					
	general welfare	of the clients, [Facility					
	Name], Inc. has in effect the following policy with regard to abuse, neglect or						
		clients by agency staff. II.					
		of abuse, neglect,					
	_	exploitation will be					
		agency policyNeglect-					
		owingly placing a client in					
		poses a threat to his/her					
		-being. Examples include					
		ted to depriving a client of					
		shelter or medical care;					
	_	dequate personal care,					
	leaving clients	unsupervised, etcInternal					
	_	fers to a situation that can					
		addressed within the					
	department (pos						
	includean inju	_					
	1	a staff person is involved,					
	- '	witnesses an incident of					
	suspected abuse	e/neglect or injury to a					
	_	f person(s) observing or					
		e aware of the incident					
	must immediate	ely: a. secure the safety of					
	the individual(s						
		,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet Page 15 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPL	E CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPL	
		15G209	B. WING			10/05/	2012
NAME OF I	DDOLUDED OD GUDDU IEI		STRI	EET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	K	651	1 NE	EBRASKA		
ARC OF	NORTHWEST IND	IANA INC, THE	HAN	ИМС	DND, IN 46323		
(X4) ID		STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAGE DEFICIENCY)			
TAG		· · · · · · · · · · · · · · · · · · ·	TAG	-	DEFICIENCI)		DATE
		begin the investigation					
	•	distc. verbally inform					
		te supervisor of the					
	-	ent and/or individual					
	responsible for t						
		bmit an incident report					
	_	eded and necessary					
		is/her supervisore.					
	secure a first aid	l assessment if there is					
	injury noted or s	suspected."					
	An interview was conducted with the						
	Quality Assuran	ice Director (QAD) and					
	Investigator of t	his investigation on					
	10/4/12 at 11:15	A.M When asked what					
	date the injury of	of unknown origin was					
	documented and	l reported, the QAD stated					
	"Monday, 9/24/	12, by the day program					
	Health and Safe	ty Tech." When asked					
	what date the in	vestigation into this injury					
	of unknown orig	gin involving client A					
	begin, the inves	tigator stated,					
	"Wednesday, 9/	26/12." When asked if					
	the investigation	n was started the day the					
	incident was rep	oorted, the investigator					
	stated "No." W	hen asked how [Group					
	home staff #3] d	lescribed [client A]'s					
	_	"He said he had a black					
	eye." When ask	ted what day [Group home					
	-	saw [client A] had a					
	-	investigator stated,					
	•	ng, 9/24/12." When					
	1	Day Program Health and					
	-	describe [client A]'s					
			1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet Page 16 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G209	B. WING		10/05/2012
NAME OF I	PROVIDER OR SUPPLIER	)	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				EBRASKA	
ARC OF	NORTHWEST IND	IANA INC, THE	HAMM	OND, IN 46323	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	1	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		tigator stated "She stated			
		ye on Monday morning,			
		asked if he contacted			
		members during the			
		e investigator stated "No,			
		n asked if he went in			
	_	ent A's reported injury,			
	the investigator				
		6/12 with [LPN #1]."			
	When asked if h	e could describe what he			
	saw, the investigator stated "His eyes				
	were red and pu	ffy and there were some			
	scratches as if he	e had been rubbing his			
	eyes because of	allergies." When asked if			
	client A had a bl	ack eye when he saw him			
	on 9/26/12, the i	nvestigator stated, "My			
	interpretation of	a black eye may be			
	different from ye	our interpretation." When			
	asked to describ	e what he considered a			
	black eye, the in	vestigator stated, "Black			
	and blue colorin	g around the eye area."			
	When asked if c	lient A's injury of			
	unknown origin	was immediately			
	reported, the inv	restigator stated "No."			
	When asked how	v he came to the			
	conclusion of th	e investigation, the			
	investigator state	ed, "Based on the nursing			
	_	[client A]s history of			
		due to allergies."			
	A day program o	observation was			
		facility owned day			
		1/12 from 1:00 P.M. until			
	2.00 F.WI Upo	n entering a conference			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet Page 17 of 42

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			
		15G209	B. WING		10/05/2012	
NAME OF I	DROWIDER OR SUBBLIEF		STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEI		6511 N	NEBRASKA		
ARC OF	NORTHWEST IND	IANA INC, THE	HAMM	10ND, IN 46323		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	RIATE	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	BEI ICEE/CT)	DATE	
		w [Day Program Health				
	and Safety Tech #1], [client A] was					
	_	inference table. Day				
		risor #2 and Health and				
	1 *	were asked if they could				
		A's eye. Both responded,				
	"He has a black eye."  An interview with Day Program Health and Safety Tech #1 was conducted on 10/4/12 at 1:10 P.M Day Program Health and Safety Tech #1 indicated, client A entered the day program on					
	Monday mornin	g, 9/24/12 with a black				
	eye. When aske	ed if she could describe				
	client A's eye, sl	ne stated "It was dark				
	black and blue f	rom the inner to outer				
	underneath eye.	He had a dark red mark				
	on the side by hi	is temple and a few				
	scratches, like so	omeone had punched him.				
	His eyes were no	ot red, or swollen and his				
	eye ball was not	red in color, like when				
	someone has all	ergies." When asked how				
	client A explain	ed how he got the injury,				
	she stated, "He s	said someone beat him up				
	when he was at	home." When asked if				
	group home staf	f informed her of the				
	injury when tran	sporting to the day				
	program, she sta	ited "No." When asked				
	what is the facil	ity's policy and procedure				
	for reporting inj	uries of unknown origin,				
	Day Program He	ealth and Safety Tech #1				
l	stated "We must	t immediately notify our				
		mmediately document on				
	_	-				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 18 of 42

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:  15G209	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	— COM	TE SURVEY  SPLETED  05/2012	
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	an internal incident/accident report and immediately report it to BDDS."					
	9-3-2(a)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 19 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G209			LDING	ONSTRUCTION  00	(X3) DATE ( COMPL 10/05/	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE EBRASKA OND, IN 46323	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W0153	The facility must of mistreatment, rinjuries of unknow immediately to the officials in accord through establish.  Based on record facility failed for of unknown orig sampled clients (immediately to the Findings include A review of the povelopmental I (BDDS) reports facility's administ at 1:55 P.M ReBDDS reports in Incident dated 9/to the Health and the weekend at had a fight with a hit him in his facility incident to Stated he forgot.  A review of investigation of the stated he forgot.	review and interview, the of 1 of 1 incident of injury in involving 1 of 2 (client A), to report the administrator.  : facility's Bureau of Disabilities Services was conducted at the strative office on 10/2/12 eview of the facility's dicated:  [24/12: "[Client A] stated I Safety Tech, that over his family (sic) house, he can unnamed male, who see. [Client A] did not to staff over the weekend.	W0	153	A procedure is in place but wa not followed in this instance. Thealth and Safety Tech and the DSPs will be retrained on reporting procedures and train will be documented. (10/29/12 To ensure future compliance a person informed of incident of abuse, neglect, exploitation or injury of unknown origin will inform the administrator prompafter being made aware of incident.	The ne ning ning any	10/29/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 20 of 42

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G209			ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 10/05/2012
	PROVIDER OR SUPPLIE		6511 N	ADDRESS, CITY, STATE, ZIP CODE EBRASKA OND, IN 46323	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	at 2:10 P.M R indicated the following	eview of the record lowing:			
	home staff #3]: saw a black eye [client A] about home, asked [cl home over week #3] assumed it r then[Group ho recorded it in th incident report was on duty Mo  An interview was Service Coordin administrative of A.M The SC i not immediately home staff to th stated "Incident	Phone Interview: [Group [Group home staff #3] Monday morning asked it was told it happened at ient A] he said he went tend [Group home staff must have happened ome staff #3] says he e log but did not do an[Group home staff #3] inday morning."  The sac conducted with the stator (SC) at the facility's effice on 10/4/12 at 11:55 indicated the incident was arreported by the group e administrator. The SC is are to be reported the administrator."			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 21 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00			COMPLETED	
		15G209	B. WIN			10/05/2012	
			1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	<u>.</u>		6511 NI	EBRASKA		
	NORTHWEST INDI	ANA INC, THE		HAMMO	OND, IN 46323		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG	483.420(d)(3)	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE	DATE	
W0154	STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.		wo	WO154		nr 10/29/2012	
	interview for 1 or of injury of unknown of 2 sampled clief failed to conduct.  Findings include  An evening obset the group home of P.M. until 6:30 F. group home, [clief have dark black his inner to outer A] was asked when stated "A big eye." When asked the person hit him.	ation, record review and of 1 investigation record nown origin, involving 1 ents (client A) the facility a thorough investigation.  Evaluation was conducted at on 10/1/12 from 5:30  P.M Upon entering the ent A] was observed to and blue coloring from a left eye. When [client nat happened to his eye, white boy hit me in my ed where he was when m, he stated "At home."  The Direct Support (DSP) was conducted at	WO	154	The Quality Assurance Director shall review notification dates responsibilities with investigation when the investigation is assigned. Upon completion, the investigation shall be provided the responsible administrator. To monitor completion and compliance the Quality Assurance Director shall devel a database for tracking investigations.	and ors ne to	
	DSP #1 stated "V [client A] got the said he got it at I picnic and now t rubbing his eyes	on 10/1/12 at 5:10 P.M We don't know where e black eye. At first he nome, then he said at the hey said it's from him because he has					
,	allergies."						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 22 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING (COMPLETED)				
		15G209	B. WING		10/05/2012	
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	ANA INC, THE		EBRASKA OND, IN 46323		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
	A review of the dependent of the Health and the weekend at had a fight with hit him in his factoring incident to Stated he forgot.  A review of investated he forgot.  A review of investated he forgot.  A review of investated he forgot.  The stated he forgot.  The stated he forgot.  The stated he followed at the said he got in figure of the said he got in figure of the said he got in figure allergies and his causing 'Black end hitBased on the the changing (so	facility's Bureau of Disabilities Services was conducted at the strative office on 10/2/12 eview of the facility's dicated:  224/12: "[Client A] stated I Safety Tech, that over his family (sic) house, he an unnamed male, who be. [Client A] did not to staff over the weekend."  estigation record #18085 was conducted on 10/2/12 eview of the record				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 23 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  COMPLETED				EY	
	or comment.	15G209	A. BUI B. WIN	LDING		10/05/2012	
NAME OF B	DOVED OD SLIDDLIED		B. WIIV		DDRESS, CITY, STATE, ZIP CODE		
	ROVIDER OR SUPPLIER				EBRASKA		
	NORTHWEST INDI		HAMMOND, IN 46323				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL	PROVID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COM	(X5) IPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	E	DATE
	hit and caused th	ne 'Black eye'					
	inadvertently hir	mself."					
	"Date 9/26/12Phone Interview: [Group						
	-	[Group home staff #3]					
	=	Monday morning asked					
		it was told it happened at ent A] he said he went					
	_	_					
	home over weekend [Group home staff #3] assumed it must have happened then[Group home staff #3] says he						
	recorded it in the	e log but did not do an					
	incident report	[Group home staff #3]					
	was on duty Mor	nday morning."					
	"Data 9/23/12 I	Phone Interview: [Group					
		[Group home staff #4]					
	-	d Saturday and Sunday at					
		Home. She worked an					
	8:00 A.M. to 10:	00 P.M. shift. She stated					
	there was not any	y conflict with the other					
	_	nt A]. They did go to the					
		ut he did not go home					
	• `	he did the previous					
	· · · · · · · · · · · · · · · · · · ·	did not notice anything					
	wiong with fils e	eye during her shift."					
	Date 9/26/12I	Main Center: [Service					
		At approximately 10					
	A.M. on 9/24/12	I received a call from					
	[Day program H	ealth Safety Tech name]					
		t [client A] came into the					
		ck eye. [Client A] told					
	staff that he was	at his family's house and					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 24 of 42

	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G209			ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 10/05/2012
	PROVIDER OR SUPPLIED		6511 N	ADDRESS, CITY, STATE, ZIP CODE EBRASKA OND, IN 46323	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	him in the eye. when I went to to [client A], he the the picnic in the guy punched hir stated he hit the knew the guy arnice.' I asked if person and he in he's like me. He questions on 9/2 the second person has a history of seasonal allergie BSP (Behavior targeted behavior "Date 9/26/12 Director]: [Servinformed me that eye and that she it. He said that Grounds talking bathroom and the When asked whe A] stated he hit Coordinator #1] [client A] indicate white guy that he conversation with [Service Coordinator of the conv	and a big white man hit Through further questions the group home to talk to ten told me that he was at bathroom and the white m in the eye. He also guy back. I asked if he ad he said 'No but he was the guy was a family atterrupted and said 'No te talks like me.' Later to did not determine who on was. [Client A] also seizures and severe es. [Client A] also has a Support Plan) with a or of false reporting."  Main: [Behavioral Health vice Coordinator #1] at [client A] had a black had talked to him about the was at the Fair to a male client in the that that client hit him. at he did about it [client thim back. [Service 's conversation with ted that this was a big the was having a th while in the bathroom. mator #1] and I developed sidential male consumers thad a conversation with			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 25 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		15G209	B. WIN	G		10/05/2012
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					EBRASKA	
ARC OF	NORTHWEST IND	IANA INC, THE		HAMMO	OND, IN 46323	
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		oking to have him look at				
		gure out which client he				
		on with. [Quality				
		tor #1] came to my office				
	_	coordinator #1] and I were				
	_	ist. I forwarded the list to				
		nator #1] and then went to				
	a meeting."					
	"Date 9/26/12[Day Program Supervisor #1]: The morning of September 24, 2012,					
	[Health and Safe	ety Tech #1] reported to				
	me that [client A	a], got into a fight when				
	he went home. I	stated that he was at the				
	picnic on Saturd	ay, so [Health and Safety				
	Tech #1] called	[Service Coordinator #1]				
	to find out if he	was there and [Service				
	Coordinator #1]	told [Health and Safety				
	Tech #1] that he	went home after the				
	picnic. [Health a	and Safety Tech#1] filled				
	out an Incident/A	Accident report and did a				
	BDDS (report)."					
	"Date 9/26/12\	West[Health and Safety				
		arriving at the center I				
		nt A] who stated to me				
	1	had a fight. (sic) I asked				
	1	e), he said a boy hit him				
	• • •	ght. I asked where and				
	1	know (sic). I asked do				
		ing about the boy, was he				
	1 ~ ~ ~	no. I told him to have a				
	<b>'</b>	informed [Day Program				
		that [client A] was in my				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet Page 26 of 42

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209	A. BUI	LDING	NSTRUCTION 00	COMP	E SURVEY LETED 5/2012
		15G209	B. WIN			10/08	0/2012
NAME OF I	PROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE, ZIP CODE EBRASKA		
ARC OF	NORTHWEST IND	IANA INC, THE			DND, IN 46323		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)		TAG	BEFFERENCY		DATE
		he had been in a fight. I a black mark underneath					
	_	redness and scratches on					
		his eye socket. She stated					
	_	happen here. I told her I					
		ntact [Service Coordinator					
		knew and had the staff					
		t report and a BDDS. I					
		Coordinator #1], and					
	_						
	informed her of [client A]'s injuries. She stated she had not been informed. I told her I would be doing an incident report and [client A] stated he was at home						
		appen (sic). After further					
		informed me that [client					
		fter the picnic, to question					
		e, the group home or his					
		Client A] would know the					
		ted [client A] which home					
		with the other consumers					
		me with sister and					
	I	ted his family home. I					
		Coordinator #1] and					
	_	it [client A] said it was his					
		he told me to make sure					
	<u> </u>	incident report and the					
		o make sure I put that the					
		ot happen at the group					
		family home. I informed					
	· ·	upervisor #1] of my					
		th [Service Coordinator					
		be doing a BDDS and					
		Upon further questioning,					
	_	it happen at home. When					
		- *					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 27 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  OO COMPLETED				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G209	A. BUILDING 10/05/2012				
		100200	B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE	10/03/2012	
NAME OF P	PROVIDER OR SUPPLIER			1	EBRASKA		
	NORTHWEST INDI	ANA INC, THE			DND, IN 46323	,	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME TAG (EACH CORRECTIVE ACTION SHOULD THE APPROPRIME TAG (EACH CORRECTIVE A		COMPLETION DATE	
1710		nformed [Day Program		1110		BATE	
		nd she said [client A]					
		at's when [Service					
	•	asked me to ask [client					
	_	because he went to his					
	family house after						
	"Date 9/26/12: West Center[Client A]:						
		stionsDo you live in					
	Nebraska Group Home?'Yes.'Did you						
	do anything this last weekendNo						
	answerDid you	go to the					
	picnic?'Yes.'	Did you have fun?'Yes,					
	I rode the swing.	'What happened to your					
	eye?'Woke up						
		hit you?'No.'Are the					
	group home staff						
		you like the group home					
		re the center staff mean					
		So you just woke up and					
	your eye was lik	e that'?'Y es.'					
		th Licensed Practical					
	` /	was conducted on					
		P.M When asked if she					
		a's injury of unknown					
		tated "I am not the nurse					
		group home, but I did go					
	_	nt A] on Wednesday,					
		f his eyes looked red and					
	· ·	eye, but like he had					
	allergies."						
	An interview wa	s conducted with the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 28 of 42

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE		
AND PLAN	OF CURRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G209	B. WIN			10/05/	ZU 1Z
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ADC OF	NORTHWEST INDI	ANA INC THE			EBRASKA		
		·		<u> </u>	OND, IN 46323		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	, The state of the	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		ce Director (QAD) and		TAU			DATE
	'	nis investigation on					
	_	A.M When asked what					
		f unknown origin was					
		reported, the QAD stated					
	1	2, by the day program					
		y Tech." When asked					
		vestigation into this injury					
		in involving client A					
	begin, the invest						
	"Wednesday, 9/26/12." When asked if						
		was started the day the					
	_	orted, the investigator					
		nen asked how [Group					
		escribed [client A]'s					
	" "	"He said he had a black					
	*	ed what day [Group home					
		saw [client A] had a					
	<u> </u>	investigator stated,					
		ng, 9/24/12." When					
	_	Day Program Health and					
	1 -	describe [client A]'s					
	" "	rigator stated "She stated					
	l -	ye on Monday morning,					
		asked if he contacted					
	client A's family	members during the					
	investigation, the	e investigator stated "No,					
		n asked if he went in					
	person to see clie	ent A's reported injury,					
	the investigator s	stated, "Yes, on					
	Wednesday, 9/26	6/12 with [LPN #1]."					
	When asked if he	e could describe what he					
	saw, the investig	ator stated "His eyes					
	were red and puf	fy and there were some					
	I .				l		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 29 of 42

	OF CORRECTION  OF CORRECTION  15G209	(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION  00	COM	E SURVEY PLETED 5/2012	
	PROVIDER OR SUPPLIER  NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	scratches as if he had been rubbing his eyes because of allergies." When asked if client A had a black eye when he saw him on 9/26/12, the investigator stated, "My interpretation of a black eye may be different from your interpretation." When asked to describe what he considered a black eye, the investigator stated, "Black and blue coloring around the eye area." When asked if client A's injury of unknown origin was immediately reported, the investigator stated "No." When asked how he came to the conclusion of the investigation, the investigator stated, "Based on the nursing assessment and [client A]s history of rubbing his eyes due to allergies."  A day program observation was conducted at the facility owned day program on 10/4/12 from 1:00 P.M. until 2:00 P.M Upon entering a conference room to interview [Day Program Health and Safety Tech #1], [client A] was sitting at the conference table. Day Program Supervisor #2 and Health and Safety Tech #1 were asked if they could describe client A's eye. Both responded, "He has a black eye."  An interview with Day Program Health and Safety Tech #1 was conducted on 10/4/12 at 1:10 P.M Day Program Health and Safety Tech #1 was conducted on 10/4/12 at 1:10 P.M Day Program Health and Safety Tech #1 indicated,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 30 of 42

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  00			(X3) DATE S COMPL		
ANDILAN	OI CORRECTION	15G209		LDING		10/05/	
		100200	B. WIN		PPPPG GYMY GM :	10/00/	-V 12
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE	6511 NEBRASKA HAMMOND, IN 46323				
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
		the day program on					
		g, 9/24/12 with a black					
		d if she could describe					
	_	e stated "It was dark					
		om the inner to outer					
		He had a dark red mark					
	_	s temple and a few					
	•	omeone had punched him.					
		ot red, or swollen and his					
	*	red in color, like when					
		ergies." When asked how					
	_	ed how he got the injury,					
		aid someone beat him up					
		nome." When asked if					
		f informed her of the					
		sporting to the day					
		ted "No." When asked					
		ty's policy and procedure					
		uries of unknown origin,					
		ealth and Safety Tech #1					
		immediately notify our					
	•	nmediately document on					
		ent/accident report and					
	immediately repo	ort it to BDDS."					
	9-3-2(a)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 31 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		15G209	B. WING		10/05/2012		
				ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIE	R		EBRASKA			
ARC OF	NORTHWEST IND	IANA INC, THE		OND, IN 46323			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
W0331	483.460(c) NURSING SERV	UCES					
		provide clients with nursing					
		dance with their needs.					
			W0331	A procedure is in place but wa	as 10/29/2012		
				not followed in this instance. T			
				Community Services Nurse wi			
		vation, record review and		be retrained in injury assessm	ent		
	interview for 1 of	of 2 sampled clients		procedures. (10/29/12) To ensure future compliance t	he		
	(client A), the fa	acility failed to provide		Community Services Nurse wi			
	nursing services	for the clients injury.		assess all clients within 24 hor			
				of any reported injury. Nurse v			
	Findings include:			determine if any further medic			
	C			treatment is required and follo			
	An evening obse	ervation was conducted at		up on the recommendation whe further treatment is warranted.			
	_	on 10/1/12 from 5:30		luttier treatment is warranted.	•		
	• •	P.M Upon entering the					
		ient A] was observed to					
		and blue coloring from					
		er left eye. When [client					
		hat happened to his eye,					
	_						
	_	white boy hit me in my					
	_	ted where he was when					
	the person hit hi	m, he stated "At home."					
	An interview wi	ith Direct Cunnert					
		th Direct Support					
		(DSP) was conducted at					
		on 10/1/12 at 5:10 P.M					
		We don't know where					
	1 2 2	e black eye. At first he					
		home, then he said at the					
	picnic and now	they said it's from him					
	rubbing his eyes	s because he has					
	allergies."						
			i i		1		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet Page 32 of 42

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G209			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/05/2012
	PROVIDER OR SUPPLIED		6511 N	ADDRESS, CITY, STATE, ZIP CODE EBRASKA OND, IN 46323	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	A review of the Developmental (BDDS) reports facility's admini at 1:55 P.M R BDDS reports in Incident dated 9 to the Health and the weekend at I had a fight with hit him in his fareport incident t Stated he (client A review of involuted 9/26/12 w at 2:10 P.M R indicated the followed the properties of the properti	facility's Bureau of Disabilities Services was conducted at the strative office on 10/2/12 eview of the facility's indicated:  /24/12: "[Client A] stated d Safety Tech, that over his family (sic) house, he an unnamed male, who ce. [Client A] did not o staff over the weekend. EA) forgot."  estigation record #18085 as conducted on 10/2/12 eview of the record lowing:	TAG	DEFICIENCY)	DATE
	Client keeps cha nothing happene said he got in fig client did not go weekend in ques allergies and his causing 'Black e looked at eye an would consider hitBased on the	orting this allegation: anging his story, now says edAt one point client ght at family home but to family home the stionClient has seasonal tory of rubbing eyes and ye' to appearNurse d did not see anything she a black eye from being the nursing evaluation and tometimes fictious) stories to the 'Black eye'			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 33 of 42

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209	LDING	NSTRUCTION  00	(X3) DATE COMPL 10/05	LETED
	PROVIDER OR SUPPLIER		 6511 NE	DDRESS, CITY, STATE, ZIP CODE EBRASKA DND, IN 46323	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) nself."	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	"Date 9/26/12I home staff #3]: saw a black eye [client A] about home, asked [cli home over week #3] assumed it n then[Group ho recorded it in the incident report was on duty Mor "Date 9/23/12I home staff #4]: stated she worke Nebraska Group 8:00 A.M. to 10: there was not an clients and [clients and [clie	Phone Interview: [Group [Group home staff #3] Monday morning asked it was told it happened at ent A] he said he went end [Group home staff nust have happened me staff #3] says he e log but did not do an [Group home staff #3]				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 34 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G209	B. WING		10/05/2012
		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER	R	6511 N	EBRASKA	
ARC OF	NORTHWEST IND	IANA INC, THE	HAMM	OND, IN 46323	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
	him in the eve.	Through further questions			
	1	the group home to talk to			
		en told me that he was at			
		bathroom and the white			
	_	n in the eye. He also			
	0	guy back. I asked if he			
		id he said 'No but he was			
	1				
		the guy was a family			
	-	nterrupted and said 'No			
		e talks like me.' Later			
	_	25 did not determine who			
		on was. [Client A] also			
	1	seizures and severe			
	seasonal allergie	es. [Client A] also has a			
	BSP (Behavior S	Support Plan) with a			
	targeted behavio	or of false reporting."			
	"Date 9/26/12]	Main: [Behavioral Health			
	Director]: [Serv	vice Coordinator #1]			
	informed me that	at [client A] had a black			
		had talked to him about			
	1 -	he was at the Fair			
		to a male client in the			
	_	at that client hit him.			
		at he did about it [client			
		him back. [Service			
	_	's conversation with			
	_	ated that this was a big			
	white guy that h				
		th while in the bathroom.			
	_	nator #1] and I developed			
		sidential male consumers			
		had a conversation with			
	nım and were lo	oking to have him look at			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet Page 35 of 42

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S COMPLE	
AND PLAN	OF CORRECTION	15G209	A. BUILD	ING	00	10/05/2	
		130203	B. WING		DDDDGG GYRY GRAND GYD GODD	10/03/2	-012
NAME OF I	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	DIANA INC, THE			DND, IN 46323		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		R LSC IDENTIFYING INFORMATION)		ΓAG	DEFICIENC!)		DATE
		igure out which client he ion with. [Quality					
		ctor #1] came to my office					
		Coordinator #1] and I were					
	_	list. I forwarded the list to					
	1 -	nator #1] and then went to					
	a meeting."	nator #1] and then went to					
	a meeting.						
	"Date 9/26/12	[Day Program Supervisor					
		ng of September 24, 2012,					
	[Health and Safety Tech #1] reported to						
	me that [client A], got into a fight when						
	-	I stated that he was at the					
		lay, so [Health and Safety					
	_	[Service Coordinator #1]					
	_	was there and [Service					
		told [Health and Safety					
	1	e went home after the					
	_	and Safety Tech#1] filled					
		Accident report and did a					
	BDDS (report).						
	"Date 9/26/12	West[Health and Safety					
	Tech #1]: Upor	n arriving at the center I					
	was met by [clie	ent A] who stated to me					
	look at my eye l	I had a fight. (sic) I asked					
	what happen (si	c), he said a boy hit him					
	and they had a f	fight. I asked where and					
	he stated I don't	know (sic). I asked do					
	you know anyth	ing about the boy, was he					
	a friend, he said	no. I told him to have a					
	seat. I went and	l informed [Day Program					
	Supervisor #1],	that [client A] was in my					
	office, he stated	he had been in a fight. I					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet Page 36 of 42

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
		15G209	A. BUILDING B. WING		10/05/2012		
			В. WПV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				6511 NE	EBRASKA		
ARC OF NORTHWEST INDIANA INC, THE				HAMMC	DND, IN 46323		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
	-	a black mark underneath					
		redness and scratches on					
	_	his eye socket. She stated					
		happen here. I told her I					
		tact [Service Coordinator					
	_	knew and had the staff					
		report and a BDDS. I					
	-	Coordinator #1], and					
	_	[client A]'s injuries. She					
		ot been informed. I told					
		oing an incident report					
	and [client A] stated he was at home						
	when incident happen (sic). After further						
	questioning, she informed me that [client						
	A] went home after the picnic, to question						
	him which home, the group home or his						
	family home. [C	lient A] would know the					
		ed [client A] which home					
	his group home v	with the other consumers					
		ne with sister and					
		ted his family home. I					
	_	Coordinator #1] and					
		t [client A] said it was his					
	family home. Sh	ne told me to make sure					
	when I make the	incident report and the					
	BDDS to make s	ure I put that the					
	altercation did no	ot happen at the group					
	home, but at the	family home. I informed					
	[Day Program Su	apervisor #1] of my					
	conversation with	h [Service Coordinator					
	#1], and I would	be doing a BDDS and					
	incident report.	Upon further questioning,					
	he informed me i	it happen at home. When					
	he said home I in	nformed [Day Program					
			1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet Page 37 of 42

	OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:  15G209	(X2) MULTIPLE CO  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 10/05/2012		
NAME OF PROVIDER OR SUPPLIER  ARC OF NORTHWEST INDIANA INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
TAG	Supervisor #1] and she said [client A] was at picnic, that's when [Service Coordinator #1] asked me to ask [client A] which home, because he went to his family house after the picnic."  "Date 9/26/12: West Center[Client A]: Open ended questionsDo you live in Nebraska Group Home?'Yes.'Did you do anything this last weekendNo answerDid you go to the picnic?'Yes.'Did you have fun?'Yes, I rode the swing.'What happened to your eye?'Woke up and it was like that.'Anybody hit you?'No.'Are the group home staff mean to you?'No.'Do you like the group home staff?'Yes.'Are the center staff mean to you?'No.'So you just woke up and your eye was like that?'Yes.'  A review of client A's record was conducted at the facility's administrative office on 10/2/12 at 3:30 P.M A review of client A's record failed to indicate nursing assessments to address client A's black eye or to indicate the client was sent to a physician for an assessment of his black eye. The last entry in client A's record indicated:	TAG	DEFICIENCY)		DATE		
	"9/19/12Audiogram-normal hearing in each ear, recommend re-eval in 3 yearsRTO (return) 3 yr (3 years).						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 38 of 42

	of correction identification number:  15G209	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMPLETED 10/05/2012		
NAME OF PROVIDER OR SUPPLIER  ARC OF NORTHWEST INDIANA INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	An interview with Licensed Practical Nurse #1 (LPN) was conducted on 10/3/12 at 2:49 P.M When asked if she assessed client A's injury of unknown injury, LPN #1 stated "I am not the nurse assigned to that group home, but I did go and look at [client A] on Wednesday, 9/26/12. Both of his eyes looked red and raw, not a black eye, but like he had allergies."  An interview was conducted with the Quality Assurance Director (QAD) and Investigator of this investigation on 10/4/12 at 11:15 A.M When asked what date the injury of unknown origin was documented and reported, the QAD stated "Monday, 9/24/12, by the day program Health and Safety Tech." When asked what date the investigation into this injury of unknown origin involving client A begin, the investigator stated, "Wednesday, 9/26/12." When asked if the investigation was started the day the incident was reported, the investigator stated "No." When asked how [Group home staff #3] described [client A]'s injury, he stated "He said he had a black eye." When asked what day [Group home staff #3] said he saw [client A] had a "black eye", the investigator stated, "Monday morning, 9/24/12." When asked how did [Day Program Health and Safety Tech #1] describe [client A]'s					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 39 of 42

		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED		
15G209		B. WING	10/05/2012			
			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF E	PROVIDER OR SUPPLIEF	C	6511 N	EBRASKA		
ARC OF	NORTHWEST IND	IANA INC, THE	HAMM	OND, IN 46323		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	ID PROVIDENCE N. I.V. OF CONDECTION		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	injury, the inves	tigator stated "She stated				
	he had a black e	ye on Monday morning,				
	9/24/12." When	asked if he contacted				
	client A's family	members during the				
	-	e investigator stated "No,				
		n asked if he went in				
		ent A's reported injury,				
	the investigator					
	Wednesday, 9/2	6/12 with [LPN #1]."				
	When asked if h	e could describe what he				
	saw, the investig	gator stated "His eyes				
	were red and pu	ffy and there were some				
	_	e had been rubbing his				
		allergies." When asked if				
	1 -	ack eye when he saw him				
		nvestigator stated, "My				
	· ·	a black eye may be				
	_	our interpretation." When				
	_	e what he considered a				
	black eye, the investigator stated, "Black					
	_	g around the eye area."				
		lient A's injury of				
		was immediately				
		restigator stated "No."				
	When asked how					
		e investigation, the				
		ed, "Based on the nursing				
	_	[client A]s history of				
		due to allergies."				
	<i>3 = 2 = 3 = 3</i>	<i>3</i>				
	A day program o	observation was				
	conducted at the	facility owned day				
	program on 10/4	12 from 1:00 P.M. until				
	2:00 P.M Upo:	n entering a conference				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet Page 40 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G209		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/05/2012	
			B. WING STREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF F	NAME OF PROVIDER OR SUPPLIER			EBRASKA	
ARC OF	NORTHWEST IND	IANA INC, THE	HAMM	OND, IN 46323	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		w [Day Program Health #1], [client A] was			
	1	iference table. Day			
	_	isor #2 and Health and			
		were asked if they could			
		A's eye. Both responded,			
	"He has a black				
		•			
		th Day Program Health			
	1	#1 was conducted on			
		P.M. Day Program			
		ty Tech #1 indicated,			
		the day program on			
	Monday morning, 9/24/12 with a black				
	eye. When asked if she could describe				
	client A's eye, she stated "It was dark black and blue from the inner to outer				
	1	He had a dark red mark			
	on the side by his temple and a few				
	scratches, like someone had punched him. His eyes were not red, or swollen and his				
	_	red in color, like when			
	1 -	ergies." When asked how			
		ed how he got the injury,			
	_	said someone beat him up			
		home." When asked if			
	group home staf	f informed her of the			
	1 0 1	sporting to the day			
		ted "No." When asked			
	what is the facil	ity's policy and procedure			
	for reporting inj	uries of unknown origin,			
	Day Program Ho	ealth and Safety Tech #1			
		immediately notify our			
	supervisor and i	mmediately document on			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet

Page 41 of 42

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR  00 COMPLETE					
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G209		A. BUILDING 00			10/05/2012		
		100200	B. WINC		ADDRESS, CITY, STATE, ZIP CODE	10/00/	2012
NAME OF PROVIDER OR SUPPLIER					EBRASKA		
	NORTHWEST IND				DND, IN 46323		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
TAG		ent/accident report and		IAG			DATE
	immediately rep	_					
	miniculatory rep	of it to BBBs.					
	No documentation	on was available for					
	review to indicate						
		client A's injury of					
	unknown injury.						
	9-3-6(a)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3DP111

Facility ID: 000736

If continuation sheet Page 42 of 42